PSYCHOLOGY CASE RECORD

Submitted to the Tamil Nadu Dr. M.G.R. Medical University in partial fulfilment of the requirements for the Diploma in Psychological Medicine Examination 2017

By
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I would like to thank my parents, family and colleagues for their support.

I would like to express my sincere thanks to all the patients and their families who kindly co-operated with me even though they themselves were suffering.

CERTIFICATE

This is to certify that this Psychological Case Record is a bonafide record of work done by **Dr. Maria Antony** during the years 2015-2017. I also certify that this record is an independent work done by the candidate under my supervision.

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CASE RECORD – 1 : Personality Assessment

Name	: Ms MC
Age	: 19 years
Gender	: Female
Marital status	: Unmarried
Language	: Hindi, English and Bengali
Education	: 11th Grade
Occupation	: Student
Socio-economic status	: Middle
Residence	: Semi-urban
Informant	:Ms MC and her parents

Presenting complaints

- Frequents quarrels with family members
- Low mood
- Lack of interest in studies
- Lack of motivation
- Multiple somatic symptoms and fainting spells
- Suicidal threats
- Decreased socialisation

History of presenting complaints

Ms MC presented with two years history of gradual decline in her interest in academics leading to little motivation in going to school resulting in the discontinuation of class 11th. She reported of a fear of failing in exams which was not present prior to the onset of the current symptoms. She complained of feeling low most of the day and avoided meeting her friends. Her social interaction with her family members decreased and she began to keep to herself in the house. Her irritability towards her family increased and became assaultive, on occasions, when her demands were not met immediately. Her irritability was directed more towards her father. She made threats of self harm when her family members disagreed with her ideologies or refused to meet her demands. However, she never made any attempts of self harm. She frequently complained of multiple aches and pain and nausea. She had multiple episodes of fainting which were not characterised by loss of consciousness, tonic-clonic movements, incontinence, up rolling of eyes, injury or confusion. The episodes always occurred when she was very distressed following a stressor and always in the presence of people and never during sleep. There is history suggestive of alleged sexual abuse by her cousin and a perceived callous and indifferent attitude by her family towards the incident. There is no history of any psychoactive substance use in abuse or dependence pattern.

There is no history of any organicity around the time of onset of her symptoms.

There is no history of any first rank symptoms in the past.

There is no history of any manic or hypomanic symptoms in the past.

There is no history of any obsessive-compulsive symptoms in the past.

Treatment history:

She was treated at different centres with multiple antidepressants of various classes along with benzodiazepines. However there was little improvement in her symptoms with the medications.

Family history:

She was born out of a non-consanguineous union. She is the eldest of two siblings. There is no history of neuropsychiatric illness in the family. Her primary attachment figure was her mother while she grew up feeling that her father was always very critical towards women and failed to understand her.

Birth and developmental history:

Her mother's antenatal period was supervised and uneventful. She was born at term of normal vaginal delivery. There is no history of birth asphyxia, neonatal seizures or jaundice or other complications. Her post-natal period was uneventful. Her developmental milestones were reported to be normal.

Educational history:

She has completed 11th standard after which she discontinued school secondary to her symptoms. Her scholastic performance was above average. She was good in extracurricular activities such as classical dance, singing and painting. She had few friends in school but all her friendships were very intense and enduring.

Sexual history:

She had female gender identity with heterosexual orientation. She denied any high risk behaviour. There is history of alleged sexual abuse from a relative in the past.

Marital history:

She was unmarried

Premorbid Personality:

She was premorbidly described to extroverted. She was enthusiastic and highly motivated. She had low frustration tolerance, was known to be impulsive and had fair moral and religious standards.

Physical examination:

Her vitals were stable and her systemic examination was within normal limits.

Mental status examination

She was moderately built and nourished. She was well kempt and maintained good eye-contact. She was alert and lucid. She was cooperative towards the examiner. She was expressive and gesticulated excessively during her interview. Her facial expressions were exaggerated. Her speech was spontaneous, dramatic, fluent with normal reaction time, garrulous productivity and normal speech. Her mood was euthymic with normal range and reactivity of affect. She denied suicidal ideation. There were no abnormalities in the form and stream of thought. Her content of thought revealed feelings of inadequacy with strong desire to prove herself before the world; dichotomy in her appraisal of people and in her decision making and hatred towards society. She denied delusions. There were no abnormalities in her perception. She was oriented to time, place and person. Her memory was intact. Her attention could be aroused and sustained. Her intelligence was above average. She had partial insight into her problems. Her test judgement was intact while her social judgement was impaired.

Provisional diagnosis:

- Emotionally Unstable Personality Disorder -- Impulsive type
- Problems in relationship with parents

Aim for psychometry:

To identify and explore significant personality factors influencing psychopathology

Tests administered and rationale for the same

1. **Sacks Sentence Completion Test**

   Rationale: It is a semi projective test developed by Dr. Sacks and Dr. Levy. It consists of 60 partially completed sentences to which the respondent adds endings. The respondent projects the attitudes towards personal experience of life. It helps to elicit ideas of self-perception.

2. **The International Personality Disorder Examination (IPDE) - ICD 10 Module Screening Questionnaire**

   Rationale: The IPDE, developed by Dr. Armander B. Loranger and colleagues, is a semi-structured clinical interview that provides a means of arriving at the diagnosis of major categories of personality disorders. The screening questionnaire is a tool used to eliminate individuals who are unlikely to have a personality disorder.

3. **The 16 Personality Factor Questionnaire**

   Rationale: It is a self report questionnaire developed by Raymond Cattell and measures the 16 personality traits and the big five secondary personality traits

4. **Thematic Apperception Test**

   Rationale: It is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes towards the self and others.

Behavioural observation:

During the entire period of assessment, she was co-operative and enthusiastic. She could comprehend the instructions and paid adequate attention. She was able to communicate appropriately. There was no performance anxiety observed.

Test findings

Sacks Sentence Completion Test

The SCT reveals her to have a strong bond with her mother. However, she feels that her mother does not appreciate her. Her relationship with her father appears

strained. Although she feels that her father is a good person, she feels that he lets her down often. Her attitude towards her family as a unit appears positive. She expresses ambivalence towards her own ability. While she has a strong desire to prove herself to be equivalent with men and has confidence in her own abilities to achieve that, she also has doubts about her ability to fulfil her potential. Secondary to her doubts, she feels that the future is bleak. She feels that her ability to cope with difficult situations in life is poor and that these situations drive her towards thoughts of self harm. She also appears to be self critical which could be in part due to her perfectionistic nature and her high expectations and which she is unable to reach. There is guilt and regret about her discontinuation of her studies. She attaches great value on trust in her friendships and her responses reveal mistrust towards her friends and superiors in her school. Her attitude towards women is negative as she is distrustful of them and her attitude towards heterosexual relationships is mixed.

IPDE:

In the IPDE Screening questionnaire, Ms MC's answers indicated high loading in the borderline and anankastic personality traits.

The 16PF Test:

The 16 PF indicates a tendency to keep a certain amount of emotional distance with others and appear detached. She prefers being alone and tends to be less concerned about how her actions or decisions affect others. She tends to be uncompromising and categorical in her approach. She tends to be reactive and easily upset with stress. She tends to have a low frustration tolerance and her ability to bounce back from disruption is low. She tends to feel unable to cope with the demands of the challenges of life. However, she also has the tendency to be serious, sober and takes life seriously. She has a tendency to be sensitive to criticism and is overcritical of herself. She tends to blame herself when things go wrong and replay incidents in her mind and speculate about whether she said or did the right thing. She also has a tendency to spend time worrying about what could go wrong in the future. She tends to be energetic and driven. However, due to her poor coping, she tends to feel pressurised and get easily frustrated by obstacles and setbacks. She may be impatient with people and situations that slow her down.

Thematic Apperception Test:

In the TAT, her stories vary in the amount of detail but are all well written. The dominant needs in the story are need for achievement, recognition, affiliation, autonomy and sentience. The stories reveal feelings of inferiority, morality, anger and rage against societal customs and rules. They also reveal strong family

ties, especially between mother and daughter. The stories reveal conflicts between needs for autonomy and deference; aggression versus harm avoidance. The dominant press is in the form of ridicule, dominance from superiors, physical illness and societal norms. However, a majority of the heroes of the stories are perseverant and are optimistic.

Conclusion

The assessment indicates that she is prone to exhibit maladaptive behaviour under stressful situations. The environment was perceived threatening and insecure. The impulsive nature of her personality, low frustration tolerance and low threshold for criticism, confirm the presence of emotionally unstable personality traits.

Management

Miss MC was admitted for psychological management and diagnostic clarification of her personality traits. As there was no evidence of a depressive syndrome, her anti-depressants and benzodiazepines were tapered and stopped.

Rapport was established with Miss MC and her family members. Her cognitive errors were brought out in sessions and attempts were made at correcting them. Behavioural techniques like activity scheduling and reinforcement strategies

were also employed to deal with her personality traits. She was taught relaxation training, coping strategies and problem solving approach.

Her family was allowed to ventilate and were psychoeducated about the nature, course and prognosis of her condition. Suicidal risks and precautions were explained. Family dynamics, structure and communication patterns were explored and parents were made aware and empowered.

CASE RECORD – 2 : Intelligence Assessment

Name : Master Y

Age : 14years and 4 months

Sex : Male

Marital status : Unmarried

Religion : Hindu

Language : Tamil

Education : Class 9

Occupation : Student

Socio-economic status : Middle

Residence : Semi urban

Informant : Master Y and his father

Reliability : Reliable and adequate

Presenting Complaints:

- Poor academic performance
- Illegible handwriting
- Difficulty in understanding Mathematics
- Inattention in school

History of Presenting Complaints:

Master Y was born of full term normal vaginal delivery. There were no perinatal complications except maternal hypertension during antenatal period. His developmental milestones were normally attained as described by his father. There is no history of significant medical illness. His academic performance was average however, parents noted that his academic performance was falling and he was finding it difficult to cope with studies. He was finding Maths increasingly difficult and teachers reported inattention in class and he was easily distracted by the external stimuli. His handwriting was illegible. He is able to perform activities of daily living by himself without prompts or supervision. He is able to travel by himself in his hometown, make minor purchases and engage in adolescent group activities. However, he is unable to play difficult games or take care of his own expenditure. He does not enjoying reading books and newspapers and has difficulty in complex calculations and abstraction.

He was taken to a physician for his deteriorating scholastic performance in each class, who advised to have a formal intelligence assessment to be done. There is no evidence to suggest any psychotic or mood symptoms at the time of his assessment.

His was independent in self care and activities of daily living.

There is no history of psychoactive substance use in an abuse or dependence pattern.

There is no history of any psychotic symptoms in the past.

There is no history of any pervasive mood symptoms in the past.

There is no history of any anxiety spectrum symptoms in the past.

There is no history of any specific personality traits in the past.

Past & Treatment History:

There is no past history of psychiatric or significant medical illnesses.

Family History:

There is no family history of neuropsychiatric morbidity. There is no history of mental retardation in his family. His parents had a second degree consanguineous marriage. He has an elder sister who is doing B.Tech. His father is a farmer by occupation while his mother is a housewife.

Birth and Development History:

His birth was of a planned pregnancy with supervised antenatal period. His mother had pregnancy induced hypertension during the antenatal period. He was born full term of normal vaginal delivery at hospital. His birth weight was not remembered by his father. His neonatal period was uneventful as remembered by father and there were no other complications like jaundice, birth asphyxia or seizure. He was adequately immunized for age. He was not noticed to have any

developmental delay by his parents, as compared to his sister and other children of the family, however his father doesn't remember the ages at which he attained specific milestones.

Emotional Development and Temperament:

He was described to be an introverted, shy child with restricted social interaction. He liked to repair electronic gadgets. There were no features suggestive of hyperactive disorder or oppositional defiant disorder.

School History:

He is currently doing his 9^{th} grade. His medium of instruction is English. He experienced difficulty in mathematics and Tamil but had average scholastic performance till class 9. Teachers would frequently complain of his illegible handwriting.

Occupational History:

He was a student and had not held a job so far.

Physical Examination:

His vital signs were stable. Systemic examination was within normal limits.

Mental Status Examination:

He was well built, nourished and was appropriately kempt. Rapport could be established. There were no abnormal motor movements. His speech was spontaneous, normal intensity and tone and relevant. His mood was euthymic with normal range and reactivity. He denied delusions, hallucinations and obsessions. He was oriented to time, place and person. His memory was intact. His attention could be aroused and sustained. His insight was partial

Provisional Diagnosis:

Borderline intelligence to mild intellectual disability.

Aims Of Psychological Testing:

As history was suggestive of poor academic performance, IQ assessment was imperative.

Test Administered:

1. Binet-Kamat Test of General Mental Abilities
2. Vineland Social Maturity Scale(VSMS)

Rationale for the Test:

1. Binet-Kamat Test (BKT) was used to assess intelligence as it is a standardised I.Q test for the Indian population

2. VSMS was administered to assess the socio-adaptive functioning.

Behavioural Observations:

Master Y was cooperative for testing and was able to comprehend the simple instructions but had difficulty in comprehension of more complex instructions. He appeared quite anxious and had to be reassured periodically. He was able to sustain his attention over the course of the assessment and was able to communicate adequately.

Test Findings:

1. On BKT, the basal age attained was 8 years, terminal age was 16 years and the mental age was 10 years and 10 months with the corresponding IQ being 75, indicating borderline mental retardation.

Function-wise Classification

Language – 12 years

Meaningful memory- 9 years

Non-meaningful memory- 8 years

Conceptual thinking- 10 years

Non-verbal thinking- 12 years

Verbal reasoning- 10 years

Numerical reasoning- 14 years

Visuo-motor skills- 10 years

Social intelligence- 12 years

Scatter is seen in the assessment – his performance is poor in items measuring meaningful and non-meaningful memory. However, on items that involve numerical reasoning, his performance is better. His social intelligence, language function, visuo-motor functions and abstract thinking was average.

2. On VSMS, his social adaptive functioning was at a age equivalent of 13 years.

   Self-help General- 7.28 years

   Self-help dressing-12.38 years

   Self help eating- 9.03 years

Communication- less than 9 years

Self direction- 15.85 years

Socialisation- less than 9 years

Locomotion- 15.85 years

Occupation- 11.25 years

Impression:

The tests are suggestive of Borderline intelligence

Management

In view of the scatter profile in BKT, inattention and illegible hand writing, Specific Learning Disability was considered as a possibility especially due the absence of any emotional or behavioural disorders.

Father was psychoeducated about the nature & course of his problems. Study techniques and integrating various modalities and styles of learning was explained. The need for repetition during learning, for reducing academic pressure and for focussing on key topics and terms was emphasized. Father was allowed to ventilate & support was provided.

CASE RECORD – 3 : Diagnostic Clarification

Name	: Miss S
Age	: 16 years
Sex	: Female
Marital status	: Unmarried
Religion	: Hindu
Language	: Tamil
Education	: Class 10
Occupation	: Unemployed
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Miss S and her parents

Presenting Complaints:

- Crying spells
- Preoccupation
- Fearfulness
- Deterioration in scholastic performance and self care

- Smiling and muttering to self
- Expressing fantastical stories involving herself

For the past 10months with insidious onset

History of Presenting Illness:

Miss S was apparently functioning well in her childhood though she had few friends with poor scholastic performance. In March 2015, her parents noticed that she was becoming increasingly preoccupied and smiling to self. These symptoms worsened with time, with Miss S expressing to her parents that she was fearful that a beggar would abduct her due to which she preferred to be in dark places. She also insisted on changing her present school as she reported that her teachers were scolding her. In school, she reported that she felt that an actress from a TV serial was talking to her though she couldn't hear her voice. She felt that TV actors were becoming her teachers and were discussing about her among themselves. She also felt that she was being discussed in popular English TV programme. She reported that these were her thoughts and these couldn't be true but she would get worried because of these thoughts. She wished that the thoughts would stop but couldn't control them. She remained so preoccupied with these thoughts that she would require prompts for self care and would frequently absent herself from school citing various reasons. With time, this fantasy thinking increased and she become extremely distressed with these though she identified these as her own thoughts, repetitive, intrusive and beyond

her control. The themes of these stories would usually revolve around her abduction and being mistreated.

There is no history of seizure, head injury, or any other organicity.

There is no history of any first rank symptoms.

There is no history of any pervasive mood syndrome.

There is no history of any generalized anxiety or panic attacks.

Treatment History:

She had been treated for these problems since March 2015- she had initially received Flupenthixol upto 6mg per day for a period of 1 month and later Quetiapine was added and increased upto 400mg per day. She had also received Aripiprazole upto 15mg per day and Clozapine upto 175mg per day. She also received Citalopram upto 30mg per day and Sertraline upto 100mg per day at various points in time. She had shown best response while on a combination of Citalopram, Sertraline, Clozapine and Quetiapine. Her index visit to MHC was in January 2016 when Inpatient stay was planned for diagnostic clarification & rationalization of medication.

Family History:

She is the only child of a third degree consanguineously married couple. There is history of psychotic symptoms in some distant relatives and learning difficulty in maternal grandmother. Her father is a businessman and her mother is a homemaker. She belongs to a nuclear family however, their relatives live nearby.

Birth and Developmental History:

The antenatal period was supervised and uneventful. Birth was full term Lower Segment Caesarean section (indication: cord around neck) with no birth asphyxia or perinatal complications. Her birth weight was 2.2 kg. Postnatal period was uneventful. All motor, social and language developmental milestones were reported to be attained normally, at appropriate age.

Educational History:

She started schooling at the age of 3 years with medium of instruction being English and curriculum being matriculation. She is described to have poor scholastic performance but being good in Tamil as compared to other subjects. There is history of three school changes and the last one being at the request of the patient herself, after onset of current symptoms. She is currently in Class 10^{th} but has had low attendance in class.

Emotional development and Temperament:

She is described to have a difficult temperament with poor coping, intense anxiety, low frustration tolerance and low persistence except in topics of her interest.

Personal History:

She is described to be a reserved person with few friends. However her social relatedness with close relatives was better. She had few interests and could talk in great length with other people with similar interests. She had poor emotional expressivity. Her interests were writing poems in Tamil and Classical music in which she was being trained. There is no history of any unusual traumatic life events.

Physical Examination:

His vitals were stable and systemic examination was within normal limits.

Mental Status Examination:

She was moderately built and adequately kempt. Rapport was shallow. However, with serial interviews, rapport could be established gradually. She was cooperative towards the examiner and made eye contact but did not maintain it

for long. Her attention was aroused and sustained. Her memory was intact. She was able to read and write in Tamil without difficulty however she had difficulty in reading and writing English. She also had difficulty in spellings in both languages. Her speech was spontaneous, at times irrelevant, with normal rate and productivity. She had difficulty in performing simple arithmetic calculations even with written prompts. Her general fund of knowledge appeared to be inadequate for her age.

Her mood was dysphoric with decreased range and reactivity. It was inappropriate but congruent to content of thought. She denied having any suicidal ideations. There were no abnormalities of form, stream or content of thought. Her content of thought revealed distress secondary to the repetitive fantastical stories; however, there were no delusions. She was observed to be smiling to self however denied hearing voices or having any perceptual abnormalities. She was oriented to time, place and person. Her attention was aroused but difficult to sustain. Her ability to abstract was poor. Her insight was impaired- Grade 2. Her personal and test judgement were intact but social judgement was impaired.

Provisional Diagnosis:

Obsessive Compulsive Disorder- predominantly obsessions **versus** Psychotic disorder-Not Otherwise Specified **versus** Moderate Depressive episode.

Autism Spectrum Disorder

Aim for Psychological testing:

To clarify symptomatology, psychopathology and diagnosis as there were as clear delusions, hallucinations and depressive symptoms could not be elicited.

Tests Administered:

1. Brief Psychiatric Rating Scale(BPRS)
2. Children's Yale Brown Obsessive Compulsive Scale (CY-BOCs)
3. Children's Depression Rating Scale(CDRS)
4. Draw a Person Test
5. Sack's Sentence Completion Test
6. Thematic Apperception Test
7. Rorschach Inkblot Test

Behavioural Observation:

She was cooperative, however became increasingly preoccupied over the course of the assessment. There was no performance anxiety observed. Impulsivity and preoccupation were the main behavioural observations during the assessments. Also she would go into elaborations of her stories, even without being asked.

1. Brief Psychiatric Rating Scale(BPRS) –

Rationale:

The **Brief Psychiatric Rating Scale** (**BPRS**) is rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour. Each symptom is rated 1-7 and depending on the version between a total of 18-24 symptoms are scored. The scale is the one of the oldest, widely used scales to measure psychotic symptoms and was developed by Dr. John Overall and Donald Gorham in 1962. It has been tested to have reliability, validity and sensitivity.

Total score- 48

She scored highest in Suspiciousness, Depressed mood, unusual thought content and feelings of guilt and anxiety.

2.Children's Yale Brown Obsessive Compulsive Scale(CY-BOCs)

Rationale-

The children's version of the Y-BOCS, or the Children's Yale–Brown Obsessive Compulsive Scales (CY-BOCS), is a clinician-report questionnaire designed to assess symptoms of obsessive compulsive disorder from childhood through early adolescence.

The CY-BOCS contains 70 questions. The CY-BOCS has been adapted into several self- and parent-report versions, designed to be completed by parent and

child working together. It has good inter-rater reliability and sensitivity for obsessive-compulsive symptoms.

Findings:

She obtained scores as follows:- Obsessions- 11, Compulsions- 6 and a total score of **17** indicative of moderate severity.

She had predominant obsessions of fear of harm to self, intrusive images and sounds, sexual thoughts and fear of being forced into becoming a Commercial Sex Worker. She admitted having compulsion of rereading and rewriting however, was unable to give a reason for it.

2. Children's Depression Rating Scale (CDRS)

Rationale

The Children's Depression Rating Scale (CDRS) is a 16-item measure used to determine the severity of depression in children. Items are measured on 3-, 4-, 5- and 6-point scales. The CDRS is derived from the Hamilton Rating Scale for Depression (HAM-D). Assessment information is based on parent, child and schoolteacher interviews. It can capture slight but notable changes in a child's symptoms. It is a reliable and valid instrument and helps to differentiate between anxiety and depressive symptoms.

Findings:

She obtained a total score of 25 with highest scores in the domains of depressed mood and social withdrawal.

3. Draw a Person Test (D.A.P.T)

Rationale:

Draw A Person Test was developed as the first measure of figure drawing as a personality assessment by Karen Machover (1949). Typically used with children and adolescents, the subject is asked to draw human figures both male and female and the picture is analyzed on a number of dimensions. Features of the figures drawn reflect underlying attitudes, concerns, and personality traits. The test provides rich clinical information which is independent from the intellectual level of the subject.

Test Findings:

The Draw-A-Person test reveals a certain level of sexual conflict and sexual immaturity as she drew a male figure before a female figure yet there was detailing in the female figure suggesting lack of interest or even hostility towards the male gender. The figures were schematic and adequate sized. The male figure drawn was immature depicting a cartoon like figure with disproportionate body parts. Transparency was also present along with some absurd verbalizations indicative of a probable fantasy or lack of reality orientation.

Elaboration and attention to detail was prominent in the female figure. There was emphasis on differential social roles of each gender. The female figure suggested a feeling of being independent and not socially conforming. Impulsivity was not noted in drawings as well as in her behaviour like snatching the pencil from the examiner's hand even before the instructions could be completed. There was moderate use of eraser with improvement following it except once when she missed completion of hand after eraser use. The strokes were mostly continuous lines made with increased pressure.

3. Sacks Sentence Completion Test

Rationale

Sacks Sentence Completion Test is a projective test developed by Dr.Sacks and Dr.Levy. It consists of 60 partially completed sentences to which the respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self perception.

Test Findings:

The SCT reveals her to have a strong dependency on her mother. She idolizes her mother however feels that her mother wants to have a son rather than her. The main emotion that she attaches to her father is respect and is dissatisfied with the amount of time he gets to spend with her. Her attitude towards her

family as a unit appears positive. She expresses ambivalence towards her own ability with regards to academic but she is very confident that she will reach her full potential in the field of music. She regards her past as a happy one however; she has doubt about her future. She has great fear of examinations. She perceives people as being supportive to her. Her attitude towards women is negative as she feels that women are mostly interested in external appearance. She had mixed feelings regarding heterosexual relationships.

4. Thematic Apperception Test

Rationale:

Thematic Apperception Test is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes towards the self and others.

Test Findings:

In the TAT, the stories are of variable length depending on the amount of preoccupation. All the stories were in the third person however, there was an element of self-reference in most of the stories. The dominant themes of the stories are need for autonomy, succorance, playmirth and adventure. Many of her stories also reveal feelings of fear and exasperation leading to self harm.

Conflict between autonomy and succorance was present. She perceived her environment to be threatening in the form of dominance and aggression.

5. Rorschach Ink Blot Test

Rationale:

Rorschach Ink Blot Test is also a projective test which provides an understanding of structure of the personality, probable psychosis if any, affectional needs and the ego strength. It also indicates degree of psychopathology.

Test Findings:

In the Rorschach protocol, she gave 10 responses with rejection of 2 cards suggestive of low productivity and mentation. Insensitivity to shading indicates her poor development of need for affection and basic defect in her personality organization resulting in poor adjustment to life. There are low numbers of popular responses and poor form level indicative of weak ties with reality. High animal percentage indicates a stereotyped attitude towards life. The low number of human responses indicates her tendency to establish a wall between herself and others and isolate herself. There was one personalized explanation given for one of the responses. There is indication of colour disturbance suggesting anxiety. Under emphasis of *d* responses reiterate his tendency to lack recognition

of everyday problems and facts. Content analysis indicates lack of variety in content suggestive of intellectual deficiency.

Summary of Test Findings:

There was no evidence suggestive of depressive features; however an obsessive thought process was present. There were disturbances in the area of interpersonal relatedness and emotional expressiveness. She had a poor personality organization was unable to relate to the different aspects of her environment which she perceived as threatening. Reality orientation was weak and she showed proneness towards psychotic tendencies.

Final Diagnosis:

Obsessive Compulsive Disorder- predominantly obsessions

Autistic Spectrum Disorder

Management

She was admitted for diagnostic clarification and appropriate treatment. Pharmacologically, her medications were all tapered and stopped initially and Fluoxetine trial upto 50mg per day was initiated after Serial MSEs and Observation in Ward, with the Probable Diagnosis of Obsessive Compulsive

Disorder with Pervasive Developmental Disorder Traits. Risperidone was added as augmentation strategy.

She was taught thought stopping and distraction methods for the obsessions. Cognitive Behavioural Therapy was attempted with her maintaining a cognitive diary. An activity schedule was given for her day to day routine work. She was engaged in Occupational Therapy during the hospital stay. Anxiety reduction techniques like Jacobson's Progressive Muscular Relaxation Techniques and Deep Breathing exercise were demonstrated. The parents were allowed to ventilate and the nature of her problem was explained. In view of her compromised intelligence, underlying Autism Spectrum Disorder, OCD and probable emerging psychosis parents were advised to reduce academic expectations and to engage her in simple structured activities. Regular follow up was suggested with plan to monitor for psychotic symptoms.

CASE RECORD –4 : Diagnostic Clarification

Name	: Mr. F
Age	: 20 years
Sex	: Male
Marital status	: Unmarried
Religion	: Muslim
Language	: Hindi
Education	: 11th Standard(discontinued)
Occupation	: Unemployed
Socio-economic status	: Middle
Residence	: Semi urban
Informant	: Mr. F and his parents

Presenting Complaints:

- Preoccupation
- Anxiety
- Repetitive thoughts of harm to self by others for unknown reason associated with fear

- Suicidal ruminations
- Repetitive doubts and checking behaviour
- Decreased socialisation
- Socio-occupational decline
- Decreased sleep and appetite

For 1 ½ year

History of Presenting Illness:

Mr. F was apparently functioning well in his childhood. There is probable history of frequent physical abuse for disobedience during his childhood & adolescence by paternal uncle while his family stayed with his paternal family. However, he had good scholastic performance and good social skills in spite of these problems, which ceased after his family became a nuclear family. The symptoms started insidiously while he was studying in class 11th without any identifiable stressors. He initially noticed fear and decreased concentration due to repetitive worry of being physically harmed or verbally insulted by boys of his locality. He also expressed fear that even unrelated people were looking at him and talking about him when he was at any public place and also misinterpreting the actions of neighbours to be motivated by ill-feelings against him. These worries were not held by his family members. He was considerable preoccupied and distressed with these thoughts to the point that he refused go out of his house and eventually even discontinued schooling. He was

considerably distressed with these thoughts and could not control them. He tried to overcome these fears by praying fervently. These thoughts caused distress so much so that he had ruminations about committing suicide. He also developed the habit of repetitive checking of whether the door was locked in order to ensure that no one had entered into his house. These symptoms also caused symptoms of low self-esteem, sense of guilt, low mood, inability to enjoy previously pleasurable activities and decreased socialisation. He had decreased sleep and appetite during this period.

There is history of intentional self harm by trying to drink mosquito repellent about 5 months ago–this was of high intentionality but of low lethality. This was secondary to distress due the above mentioned symptoms.

There is no history of seizure, head injury, or any other organicity.

There is no history of any first rank symptoms.

There is no history of any pervasive mood syndrome.

There is no history of any generalized anxiety or panic attacks.

Treatment History:

He has been treated for these problems elsewhere with Escitalopram upto 10mg per day and Clonazepam upto 0.5mg per day without significant improvement. His index visit to MHC was in February 2016 when he was given the diagnosis of Prodrome of Psychosis and treated with Olanzapine upto 20mg per day. He

showed about 30% improvement with this however to be dysfunctional while at home. He was reviewed in July 2016 when the diagnosis was changed to Obsessive Compulsive Disorder- Predominantly obsessions and he was started on Fluoxetine upto 60mg per day and Olanzapine was decreased to 10mg per day on OP basis. However he continued to have symptoms hence Inpatient stay was planned for diagnostic clarification & rationalization of medication.

Family History:

He is the second child born to his parents from a non-consanguineous union. There is no family history of any neuropsychiatric illness. His father is a serviceman and his mother is a homemaker. He has two sisters- one older to him who is studying in College and a younger sister who is completing her schooling.

Birth and Developmental History:

The antenatal period was supervised and uneventful. Birth was full term normal vaginal delivery with no birth asphyxia or perinatal complications. Postnatal period was uneventful. Both motor and language developmental milestones were reported to be normal.

Educational History:

He has completed class11th after which he discontinued due to his illness. His academic performance was reported to be good. He had good interaction with his peers and teachers until the onset of his symptoms.

Sexual History:

He has male gender identity and heterosexual orientation. He denied any high risk sexual behaviour.

Marital History:

He is unmarried.

Premorbid Personality:

Premorbidly he is described to be a sociable and diligent. He also had anxious personality traits. He has good moral and religious standards.

Physical Examination:

His vitals were stable and systemic examination was within normal limits.

Mental Status Examination:

He was moderately built and adequately kempt and maintained good eye contact. Rapport was partial initially. However, with serial interviews, rapport was established gradually. He had retardation in his level of activity. His speech was spontaneous, relevant, laconic productivity but monotonous, with increased reaction time and decreased speed. His mood was dysphoric with decreased range and reactivity. He admitted having suicidal ideations but no active suicidal planning. His content of thought revealed persecutory and referential ideas with repetitive doubts and questioning and depressive cognitions. His higher mental functions were intact. His abstraction ability, insight and judgement were impaired. He had average intelligence.

Differential Diagnosis:

1. Paranoid schizophrenia- period of observation too short, course uncertain
2. Obsessive- compulsive disorder-predominantly obsessional thoughts

Aim for Psychometry:

To clarify symptomatology, psychopathology and diagnosis

Tests Administered:

1. Rating scales
2. Sack's Sentence Completion Test
3. Thematic Apperception Test
4. Rorschach Inkblot Test

Behavioural Observation:

He was cooperative to do the assessment. He was able to sustain his attention over the course of the assessment. There was slight performance anxiety observed but was able to overcome those with persuasion and encouragement. He was able to communicate without any difficulty.

1. Rating scales

Yale- Brown Obsessive Compulsive Scale

He had obsessions of violent/ horrific images, fear of acting of suicidal impulses, excessive concern with morality, superstitious fears and pathological doubt. He also had compulsions of checking locks, repeating same questions, repetitively seeking reassurance and mental rituals of praying.

His score

Obsessions- 10/ 20

Compulsions- 12/20

Total score- 22/40 suggestive of **Moderate Severity**

Positive and Negative Symptoms Score(PANSS)

Positive symptoms score- 13/49

Negative symptoms score- 13/49

General symptoms score- 32/ 112

Total score- 58/210

2. Sacks Sentence Completion Test

Rationale:

Sacks Sentence Completion Test is a projective test developed by Dr.Sacks and Dr.Levy. It consists of 60 partially completed sentences to which the respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self perception.

Test Findings:

In SCT, conflicts were found in the domains of self-ability, future and friends and acquaintances. He appears to have close ties with his parents and wants to be an ideal son to them. He has some regret that his father was not able to notice the start of his illness and bring him for timely treatment. Overall, he has a positive outlook about his family unit. Also, he appears to be preoccupied with the fear of going out of his house and guilt for not having used his time for studies properly,

when he could. This is more so because currently, his symptoms are not letting him concentrate on studies. He appears to be regretful and grudging of the past and has mixed feelings about future- primarily depending on the outcome of cure from current symptoms. There were no major conflicts in the interpersonal domains except those with friends whom he felt might be ridiculing him. There were no major conflicts regarding heterosexual relationships and has positive feelings towards women, in general.

3. Thematic Apperception Test

Rationale:

Thematic Apperception Test is a projective test used to measure the person's pattern of thought, attitudes, observational capacity and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes towards the self and others.

Test Findings:

In the TAT, the stories are very detailed and long. All the stories are in the third person and he identifies himself with the hero in most of the stories. The dominant themes of his stories are those of morality, suicide and death yet most of the stories, were optimistic. The dominant needs appeared to be the needs for autonomy, dominance, achievement, recognition, succorance, affiliation, infavoidance, counteraction and sex. The stories also reveal a press from the environment in the form of rejection, abasement, hostility and aggression. The conflicts noted are achievement and autonomy versus harm and blame avoidance.

4. Rorschach Ink Blot Test

Rationale:

Rorschach Ink Blot Test is also a projective test which provides an understanding of structure of the personality, probable psychosis- if any, affectional needs and the ego strength. It also indicates degree of psychopathology.

Test Findings:

In the Rorschach protocol, he had good productivity but rejection of cards was present. Shading responses were present indicating well-developed need for

affection. There are low numbers of popular responses (even on testing limits) and poor form level indicative of weak ties with reality. There were few whole responses and perseveration of responses was present. Overall, the protocol was suggestive of psychosis.

Conclusion:

The overall test findings were suggestive of psychosis with persecutory and referential beliefs; however he also had prominent anxiety symptoms which did not fulfill criteria for any syndrome.

Final impression:

Paranoid schizophrenia- course uncertain, period of observation too short (with prominent anxiety symptoms)

Management:

He was admitted for diagnostic clarification and appropriate treatment. As psychotic symptoms were clarified over time he was given adequate trial of Risperidone and increased upto 8mg per day. Fluoxetine was continued was at 50mg per day in view of prominent anxiety symptoms. He showed significant improvement with this.

Non-pharmacological measures were also employed like Cognitive-behavioural strategies to reduce residual psychotic symptoms, depressive and anxiety symptoms. He was taught relaxation strategies like Jacobson's Progressive Muscular Relaxation and Deep Breathing Exercises. An activity schedule was given for his day to day routine work. He was engaged in Occupational Therapy during the hospital stay. He was psychoeducated about the nature, course and prognosis of illness.

The parents were allowed to ventilate and the nature of his problem was explained to them. Their distress was acknowledged and they were supported.

Case Record-5 : Neuropsychological Assessment

Name	: Mrs. PK
Age	: 59 years
Sex	: Female
Marital status	: Married
Language	: Tamil
Education	: Class 10th
Occupation	: Anganwadi teacher
Socio-economic status	: Lower
Residence	: Rural
Informant	: Daughter

Presenting complaints:

- Increased irritability
- Change in behaviour
- Decreased sleep
- Forgetfulness

since last 4 months.

History of presenting complaints:

Mrs. PK was brought to OPD with the above mentioned complaints. Premorbidly, she is reported to be well-adjusted, responsible and hard-working lady with some anxious personality traits. She had undergone Cataract surgery in both eyes and has no other known medical co-morbidities.

She was apparently normal till about 1 year ago when she had a head-injury following a Road Traffic Accident after which she had loss of consciousness for about 5 minutes. There is no history of seizures, ENT bleed or vomiting following the injury. She had sustained a scalp laceration for which she required suturing. Imaging done at that time was reportedly normal.

She was doing well for about 8 months after the injury, when family members noticed a change in her behaviour- she started to blame her husband for not loving her anymore; being suspicious that neighbours might steal the produce from her farm or the fruits from the trees; while she herself would steal the fruits from her neighbours' trees and denied it, when questioned; hoarding behaviour; expressing the belief that someone has done black magic against her; urinating at inappropriate places in the house; having poor self-care and denying it; excessive querulousness, irrelevant speech ,inappropriate smiling, stubborn behaviour and easy irritability were also noticed.

Her family members also started receiving complaints from her workplace that she was making multiple mistakes in accounts and that her work had become shabby. The same was noticed at home also as she was unable to cook as well as

she used to earlier, she was unable to remember the proportions of ingredients in the various dishes and she was unable to remember the names of some relatives who came to her house. She was also found to be preoccupied most of the time, was not eating well and had delayed onset of sleep.

There is no history of any first rank symptoms of schizophrenia.

There is no history of manic, hypomanic or depressive symptoms.

There is no history of obsessive-compulsive symptoms or panic symptoms in the past.

There is no history of any other specific personality traits.

Past history:

She has undergone bilateral cataract surgery in the past. There is no history other medical co-morbidities.

Family history:

There is history of alcohol use in multiple male relatives. There is no history of other neuropsychiatric illness in the family.

Birth and development history:

Details are not available

Educational history:

She has completed SSLC and was reported to have above average in scholastic performance.

Occupational history:

She started working as an Anganwadi teacher since the age of 18 years. She was well-respected at her workplace as she was known to be a diligent worker. She was also responsible for the maintaining account at the Anganwadi.

Sexual history:

She was of heterosexual orientation. She had attained menopause at the age of 45 years.

Marital history:

She has been married for the past 40 years and had four children- three sons and one daughter. She stays with her husband, who is a farmer and her youngest son.

Premorbid personality:

She is described to be well-adjusted with some anxious personality traits.

Physical examination:

Her vitals were stable and systemic examination was within normal limits. There were no focal neurological deficits.

Central Nervous System Examination:

Higher Mental Function- MMSE 24/30

Cranial Nerves- No cranial nerve palsies

Motor System:

Bulk- Normal in all muscle groups

Tone- Normal in all muscle groups

Power- Grade 5 power in all four limbs

There were no involuntary movements

Sensory system:

Crude touch, Pain, Temperature- normal bilaterally

Fine touch, Vibration sense and Joint position Sense- normal bilaterally

Reflexes:

Superficial abdominal reflex- present in all four quadrants

Plantar reflex- flexor bilaterally

Deep tendon reflexes- 2+ bilaterally

Cerebellar functions- no signs of cerebellar dysfunction

There were no frontal release signs

Gait- normal

Signs of meningeal irritation- absent

Skull and spine- normal

Mental Status Examination:

She was well built and nourished. Rapport could be established. She made good eye-contact. She was seen holding tightly to her hand bag and smiling inappropriately. Her speech was spontaneous and garrulous, however, was irrelevant occasionally. Her mood was euthymic with normal range and reactivity. There was cicumstantiality in her stream of thought and content of thought revealed persecutory ideas. She denied having any perceptual abnormalities. She was oriented to time, place and person. Her immediate was intact however, her recent and remote memory were impaired. Her attention was aroused but difficult to sustain. Her intelligence was average. Her social judgement was impaired and she had partial insight into her illness.

Provisional diagnosis:

Evolving dementia

Organic personality change

Late-onset psychosis

Aims for Neuropsychological Assessment:

1. To find out the cognitive profile of Mrs. PK
2. To relate the findings to clinical presentation

Tests Administered:

1. Addenbrooke's Cognitive Examination-revised (Tamil)
2. NIMHANS Neuropsychological Battery

She was cooperative for the assessment however, she required multiple prompts to sustain her attention and persist in the tasks before her. There was no active resistance in doing the assessment. She was able to comprehend the instructions well. Her verbal communication was adequate. There was no performance anxiety observed.

Test Results:

1. Addenbrooke's Cognitive Examination-revised (Tamil)

   Her performance in the ACE-R indicated impairment in memory, fluency and language while her attention, orientation and visuospatial abilities were intact.

2. NIMHANS Neuropsychological Battery

   Divided attention:

   On the Triads Test, the total number of errors was 22, which is less than the 3rd percentile, indicative of impairment in ability to divide attention between two tasks. She was able to focus her attention on only one of the tasks that she was instructed to do.

Planning:

Planning was assessed by the Tower of London test. The total number of problems solved in the minimum number of moves is 10, which is at the 60th percentile. The mean time taken, the mean moves and the number of problems solved with minimal moves are as follows

No. of moves	Time taken	Percentile	Mean moves	Percentile	No. of prob with minimal moves
2 moves	5s	57th	2	100th	1
3 moves	36.7s	7th	4	36-54th	2
4 moves	35s	30th	4	87-100th	4
5 moves	23.3s	50-53rd	5	87-100th	3

The scores suggest minimal impairment in problem-solving ability. There is fluctuation in the score which could be due to the poor attention as the patient was able to conceptualize the problem and avoided making similar errors.

Verbal Learning and Memory:

On the Auditory Verbal and Learning test, the total number of correct words recalled is 16, which is below the 5th percentile; the immediate recall and delayed recall were 1 and 4 resp., which are both below the 5th percentile. The long term percentage retention is 133%, which is above the 95th percentile. The number of hits in the recognition trial is 16 which is above the 95th percentile.

On the passage test, her score for immediate recall was 2 which is below the 5th percentile and that for delayed recall was 0, which also below the 5th percentile.

This indicates the presence of deficits in the verbal learning and memory. However, her recognition was intact.

Impression:

The test findings suggest impairment in most domains of neuropsychological functioning including divided attention, language and verbal memory.

This is suggestive of deficits in frontal and temporal lobes.

Management:

Mrs. PK and her family were educated on the nature of illness and about the assessment results. She was treated on out-patient basis. MRI brain was done and along with other blood investigations. MRI Brain showed age-related atrophy and bifrontal white matter small lacunar infarcts. However, her symptoms appeared to be out-of-proportion to the extent of lesions seen on the MRI. She was also found to have Deficiency of Vitamin D and B12, which were corrected. She was started on Memantine and Quetiapine was added to improve sleep and decrease agitation. Strategies to deal with the behavioural problems associated with dementia were discussed with the family members. Reviews and further assessments were scheduled, as per need.